

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-010244

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED MAR 19 1962

Primary Registration District No. 393

Primary Registration District No. 1002

Registrar's No. 1174

1174

VS 300
Rev. 4/59

16008

26668

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4 1

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12 86-0

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF JAMES E. MC CORTILL CK MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY

Clay

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN

Kansas City North

Length of stay in 1b

4 mo.

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

Guardian Angel N.H.

Inside Limits
Yes ☒ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Mo.

b. COUNTY

Clay

Inside Limits
Yes ☐ No ☐c. CITY
OR TOWN

Kansas City North

Reside on Farm
Yes ☐ No ☐d. STREET
ADDRESS

3826 Antioch Rd.

3. NAME OF DECEASED
(Type or print)

First MARGARET G. JOHNSTON Middle Last

4. DATE
OF DEATH

Month 2 Day 25 Year 1962

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐Widowed ☐ Divorced ☒

8. DATE OF BIRTH

7-19-1899 62

9. AGE (last birthday)

IF UNDER 1 YEAR IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

NURSING

11. BIRTHPLACE (City and state or country)

Topeka, Kansas

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

ROBERT B. GRAHAM

13b. MOTHER'S MAIDEN NAME

SARAH J. HARDIE

14. NAME OF HUSBAND OR WIFE

LAUGHN JOHNSTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

MR. LAUGHN JOHNSTON OF THE HOME

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Squamous Cell Carcinoma, Cervix

INTERVAL BETWEEN
ONSET AND DEATH

about 1 year.

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☐20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour Month, Day, Year
a.m. p.m.20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 11-9-61 to 2-25-61 and last saw her alive on 2-25-61
Death occurred at 7 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

D.W. Newcomer Sons N. K.C. Mo. 2-27-62

Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DR. McCORMICK

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Marion D. Preston

Licensed Embalmer No. 5040

P. O. Address K.C., Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.